

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33118**
Registrar's No. **8047**

FILED OCT 2 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MISSOURI b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, 4000 ?	
d. FULL NAME OF HOSPITAL OR INSTITUTION PARK LANE HOSPITAL		d. STREET ADDRESS (If rural, give location) 12015 RIVERVIEW	
3. NAME OF DECEASED (Type or Print) ANNA		a. (First) ANNA	b. (Middle)
c. (Last) KOCH		4. DATE OF DEATH AUG, 22, 1952	
5. SEX female	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 4/26/1877
9. AGE (In years, last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME ADELBERT KOLB	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME OSCAR KOCH		ADDRESS 12015 RIVERVIEW DRIVE	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage & Left Hemiplegia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arterio Sclerosis Paraneuronal Nephritis DUE TO (b) Arterio Sclerosis Paraneuronal Nephritis DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 591X	
22. I hereby certify that I attended the deceased from July 2, 1952 , to Aug 22, 1952 , that I last saw the deceased alive on Aug 21, 1952 , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE Carl Smith MD		23b. ADDRESS 801 N. Broadway	
23c. DATE SIGNED 8-25-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8/26/52	24c. NAME OF CEMETERY OR CREMATORY FRIEDENS CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI
DATE REC'D BY LOCAL REG. AUG 25 1952	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE STROOT - CARROLL	
		ADDRESS 4600 NAT'L BRIDGE	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Albert Mayfield

Licensed Embalmer No. 3977

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.